

CERTIFICATE OF DEATH

11319

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11320
Reg. Dist. No.

11344

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5yr.2mo.2das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		e. STREET ADDRESS 201 Race Street	
3. NAME OF DECEASED (Type or print) Gertrude Willey Asmussen		4. DATE OF DEATH October 22 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-91
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Edward Willey		14. MOTHER'S MAIDEN NAME Ida Emma Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. 214-32-0827	
17. INFORMANT Eastern Shore State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome.			
INTERVAL BETWEEN ONSET AND DEATH 3 Min. ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 10/22/59	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bennoch R. Thomas		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hearn			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11336

CERTIFICATE OF DEATH

11321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>			
c. LENGTH OF STAY IN 1b <u>7 month.</u>				d. STREET ADDRESS <u>R.F.D. #3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenburn Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Stratton Blizzard</u>				4. DATE OF DEATH Month Day Year <u>10 12 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/11/1868</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Stratton</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Naomie Sherry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>COL. J. C. Blizzard, R.F.D. #3, Cambridge, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO (b) <u>Hypertensive Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>no</u> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cambridge, Md.</u>	
20f. (City or town) <u>Cambridge, Md.</u>				(County) <u>Wilmington</u>		(State) <u>Del.</u>	
21. I certify that I attended the deceased from <u>3-5</u> , 19 <u>59</u> , to <u>10-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-12</u> , 19 <u>59</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Le Compte Funeral Service</u>				DATE SIGNED <u>10-13-1959</u>			
PHYSICIAN'S NAME (Type) <u>C. E. MEERINGS</u>				M.D. <u>M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery, Co.</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington Delaware.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>				24a. REC'D BY REGISTRAR <u>OCT 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G252 11/20/59 1wk

11337

CERTIFICATE OF DEATH

Reg. Dist. No.

11322

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>Route #1 Box 54</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Boy</u> First Middle Last				4. DATE OF DEATH <u>October 25 1959</u> Month Day Year					
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-24-59</u>			
9. AGE (In years last birthday) yrs. <u>9</u>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Paul ?</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Arvella Camper</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Hazel Arvella Camper - Route #1</u>				Address <u>Cambridge Md. Box 54</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intra uterine Anoxia -</u>								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>10-24</u> , 19 <u>59</u> , to <u>10-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-25</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Albert E. Bunker</u> M.D.				ADDRESS (Street, city or town, state) <u>200 Maryland Ave. Cambridge Md.</u>					
DATE SIGNED									
PHYSICIAN'S NAME (Type) <u>Dr. Albert E. Bunker</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>10-27-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Bayly Cemetery</u>					
22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon Henry - 22 Cedar St. Cambridge, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 30 1959</u>					
24b. REGISTRAR'S SIGNATURE									

2067141XU2

CERTIFICATE OF DEATH

11301

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		DATE OF BIRTH [Faint handwritten date]	
PLACE OF BIRTH [Faint handwritten place]		OCCUPATION [Faint handwritten occupation]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF DECEASED [Faint handwritten signature]	
SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF DECEASED [Faint handwritten signature]	

10-22-22 10-22-22 10-22-22 10-22-22 10-22-22

10-22-22 10-22-22 10-22-22 10-22-22 10-22-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11338

CERTIFICATE OF DEATH

Reg. Dist. No.

11323

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 Phillips Street</u>				d. STREET ADDRESS <u>102 Phillips Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Melvin</u> Last <u>Cornish</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>19 59</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1921</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Can Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Odia Cornish</u>				14. MOTHER'S MAIDEN NAME <u>Sinia Mack</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-10-8362</u>		17. INFORMANT <u>Sinia Cornish, Cambridge, Md.</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Decompensation due to Coronary heart disease</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>10-24-</u> 19 <u>59</u> , to <u>10-26-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>October 26</u> 19 <u>59</u> , and that death occurred at <u>12</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>10-29-59</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/29/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Field Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Cambridge, Md.</u>						24a. REC'D BY REGISTRAR <u>NOV 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1932

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		M		45		JAN 15 1887		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
LABORER		HEART DISEASE		SUICIDE		10 DAYS		JAN 25 1932		BALTIMORE		BALTIMORE		BALTIMORE	
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		COUNTY	
HIGH SCHOOL		METHODIST		1908		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
JAMES H. HARRIS		MARY H. HARRIS		LABORER		HOUSEWIFE		JAN 15 1845		JAN 15 1850		BALTIMORE		BALTIMORE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		FATHER'S WITNESS		MOTHER'S WITNESS		FATHER'S ADDRESS		MOTHER'S ADDRESS		FATHER'S PHONE		MOTHER'S PHONE	
JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		FATHER'S WITNESS		MOTHER'S WITNESS		FATHER'S ADDRESS		MOTHER'S ADDRESS		FATHER'S PHONE		MOTHER'S PHONE	
JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

1932

1

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12499

11339

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMbridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMbridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CAMbridge Md. HOSP.</u>		d. STREET ADDRESS <u>133 Pine St</u>	
3. NAME OF DECEASED (Type or print) <u>MATTHEW H. CORNISH</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-89</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
INFORMANT <u>EMERSON CORNISH</u>		Address <u>CAMbridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>59</u> , to <u>October 25</u> 19 <u>59</u> , that I last saw the deceased alive on <u>October 25</u> 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-CAMbridge, Md.</u> DATE SIGNED <u>10-28-59</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>J. Edwin Fassett, M.D.</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>CAMbridge Dor. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '59</u>	
ADDRESS <u>CAMbridge Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

17332

IN

INDEX

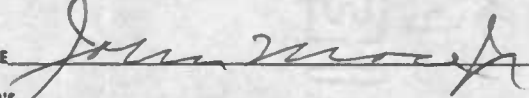
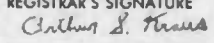
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11324

Reg. Dist. No.

11345

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FISHING CREEK			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FISHING CREEK		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle WORTEN Last CREIGHTON				4. DATE OF DEATH Month OCT Day 19 , Year 19 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 20, 1900		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME H CWARD WROTEN				14. MOTHER'S MAIDEN NAME EFFIE CREIGHTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS BRACK TESTERMAN		Address BEL AIR MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF OCT. 21, 1959		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE				ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
						24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

2212

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11340

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.J.</u> b. COUNTY <u>Unknown</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington, N.J.</u>	
c. LENGTH OF STAY IN 1b <u>7 years</u>		d. STREET ADDRESS <u>Unknown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>307 Oakley St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Abbott Ensor</u>		4. DATE OF DEATH Month Day Year <u>10 13 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-78</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Abbott</u>		14. MOTHER'S MAIDEN NAME <u>Unknown.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Le Compte Funeral Service, Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio vascular renal disease</u> DUE TO (c) <u>Arteriosclerosis, generalized.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11</u> , 19 <u>59</u> , to <u>10-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-13</u> , 19 <u>59</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Locust Street</u> DATE SIGNED <u>10-13-59</u>			
ACTUAL SIGNATURE <u>Eldridge M. Wolff</u> M.D.		DATE SIGNED <u>10-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Eldridge M. Wolff, M.D.</u>		Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetary</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>		24a. REC'D BY REGISTRAR <u>OCT 15 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13650

11346

Items 4,8 FilmG253 12-22-59 et

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD # 3, Cambridge, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD # 3, Cambridge, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		d. STREET ADDRESS 11	
3. NAME OF DECEASED (Type or print) Isaac Lerner		4. DATE OF DEATH October ? ? 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1906 2/2/1906
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit dealer-ret.		10b. KIND OF BUSINESS OR INDUSTRY Retail selling	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Lerner		14. MOTHER'S MAIDEN NAME Lena Lerner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Personal records on deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound brain 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by pistol	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ? 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 12/8/59	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF December 11, 59	
22c. NAME OF CEMETERY OR CREMATORY Montefiore Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Goldstein Funeral Home, 2729 N Broad, Phila., Pa.		24a. REC'D BY REGISTRAR DEC 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. K...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

11325

11347

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE 19x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSP		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ERNIE Middle DALE Last LLOYD		4. DATE OF DEATH Month OCT. Day 10 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 25, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LAWSON J. MASON		14. MOTHER'S MAIDEN NAME EMMA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC MYOCARDITIS DUE TO (c) GENERAL ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957 to OCT. 10, 1959 , that I last saw the deceased alive on OCT. 10, 1959 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ettore De Filippis		ADDRESS (Street, city or town, state) EASTERN SHORE STATE HOSP.	
DATE SIGNED OCT. 10, 1959		DATE SIGNED	
PHYSICIAN'S NAME (Type) ETTORE DEFILIPPIS		CAMBRIDGE, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10-13-59	22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Vernon, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilbur		24a. REC'D BY REGISTRAR OCT 14 '59	
ADDRESS Princess Anne		24b. REGISTRAR'S SIGNATURE Charles E. H. H.	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935

CERTIFICATE OF

112

STATE OF NEW YORK

IN SENATE

January 10, 1935

REPORT OF THE

COMMISSIONER OF

THE STATE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11327

Reg. Dist. No.

11348

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b After Arrival 13 Cambridge, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Levin M. Middle Marshall, Sr. Last 		4. DATE OF DEATH Month 10 Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/1907
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Marshall		14. MOTHER'S MAIDEN NAME Margaret Connors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs Charles Dean, East New Market, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.3 Meningitis DUE TO Conditions, if any, which gave rise to immediate cause (b) Broncho Pneumonia (c) DUE TO (a), stating the underlying cause lost. (c) 		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/59	
22c. NAME OF CEMETERY OR CREMATORY East New Market Cem.		22d. LOCATION (City, town, or county) (State) East New Market, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24c. REC'D BY REGISTRAR OCT 5 1959	
		24b. REGISTRAR'S SIGNATURE Arthur B. Hume	

DATE SIGNED

10/2/59

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH (County)		DATE OF DEATH	
BALTIMORE		JAN 19 1900	
FULL NAME OF DECEASED		SEX	
JOHN J. WILSON		MALE	
AGE		DATE OF BIRTH	
35		JAN 19 1865	
OCCUPATION		CAUSE OF DEATH	
CLOCK MAKER		HEART DISEASE	
RESIDENCE		MANNER OF DEATH	
1234 N. E. ST.		NATURAL	
MARITAL STATUS		EDUCATION	
MARRIED		HIGH SCHOOL	
RELIGION		POLITICAL PARTY	
CATHOLIC		DEMOCRAT	
SIGNED AND SEALED		SIGNED AND SEALED	
JAN 20 1900		JAN 20 1900	
MEDICAL EXAMINER		MEDICAL EXAMINER	
J. J. WILSON		J. J. WILSON	
BALTIMORE		BALTIMORE	
STATE OF MARYLAND		STATE OF MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11349

CERTIFICATE OF DEATH

Reg. Dist. No.

11328

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Widow's Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Daniel James Mowbray</u>		4. DATE OF DEATH <u>10 / 12 / 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Widow</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Boat</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas U. Mowbray</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hilkey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>11-5-1870</u>	
17. INFORMANT <u>M. S. Mowbray</u>		Address <u>East New Market</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Arterio-sclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 12</u> , 19 <u>55</u> , to <u>Oct 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 12</u> , 19 <u>59</u> , and that death occurred at <u>10/12/59</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James U. Thompson</u> M.D.		ADDRESS (Street, city or town, state) <u>Cambridge, Md</u> DATE SIGNED <u>10/14/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/14/59</u>	<u>East New Market</u>	<u>East New Market Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kinsler</u>		ADDRESS <u>East New Market</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 19 '59</u>		<u>Arthur S. Kinsler</u>	

11350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fisher Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Willis Middle Albert Last Richardson				4. DATE OF DEATH Month October Day 17 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 19, 1868	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Power Boat Captain				10b. KIND OF BUSINESS OR INDUSTRY Vienna, Md. R.D.		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME John Richardson				14. MOTHER'S MAIDEN NAME Georgiana Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miss Mayne L. Richardson, Seaford, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 10 days 20 yrs 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/7 , 19 59 , to 10/17 , 19 59 , that I last saw the deceased alive on 10/17 , 19 59 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold B. Plummer				ADDRESS (Street, city or town, state) P.O. Box 184 Pester Md			
PHYSICIAN'S NAME (Type) Harold B. Plummer				DATE SIGNED 10/14/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shoval				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE OCT 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. <u>DORCHESTER</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MADISON</u> c. LENGTH OF STAY IN 1b <u>LIFE</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>NONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X MADISSON</u> d. STREET ADDRESS <u>NONE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>SHAFFNER</u> <u>SLACUM</u>		4. DATE OF DEATH Month Day Year <u>OCT.</u> <u>29,</u> <u>19</u> <u>59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 2, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>JOS. A SHAFFNER</u>		14. MOTHER'S MAIDEN NAME <u>IDA SHAFFNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DAWSON SLACUM SR.</u>		Address <u>MADISON MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OLD LEFT HEMIPLEGIA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/8</u> , 19 <u>59</u> , to <u>29 OCT</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/8</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>105 CHURCH ST</u> <u>10/30/59</u> ACTUAL PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR</u> <u>Cambridge Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 1, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EAST NEW MARKET</u>	22d. LOCATION (City, town, or county) (State) <u>EAST NEW MARKET MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LE COMPTE FUNERAL SERVICE</u>		ADDRESS <u>CAMBRIDGE MARYLAND</u>	24a. REC'D BY REGISTRAR <u>NOV 2 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 FilmG251 11-6-59 at
CERTIFICATE OF DEATH

Reg. Dist. No.

11332

11341

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b LI	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE MARYLAND HOSP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE First ANN Middle WILCOX Last		4. DATE OF DEATH Month OCT Day 24 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1882
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ROBERT HUBBARD		14. MOTHER'S MAIDEN NAME MARGARET PHILLIPS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ODIE WILCOX		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 10/21 , 19 59 , to 10/24 , 19 59 , that I last saw the deceased alive on 10/24 , 19 59 , and that death occurred at 7:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust St CAMBRIDGE, MARYLAND DATE SIGNED 10/29/59 ACTUAL SIGNATURE W. H. Hanks M.D. PHYSICIAN'S NAME (Type) W. H. Hanks M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY SPEDDEN CEMETERY		22d. LOCATION (City, town, or county) (State) R F D # 3 CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE		24a. REC'D BY REGISTRAR NOV 2 '59	
ADDRESS CAMBRIDGE MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

11342

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Vienna</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>P. O. Box 35</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willey</u>			4. DATE OF DEATH Month Day Year <u>October 27 1959</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 26, 1959</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>17 30</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>James Howard Willey</u>			14. MOTHER'S MAIDEN NAME <u>Peggy Ann Keene</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mother Vienna, Md. P. O. Box 35</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Extreme Prematurity - 22 wks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>17 1/2 hrs</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partial Premature Separation of Placenta then Labor</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>59</u> , to <u>10-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-27</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>W. Baumann</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Wilbur N. Baumann</u> <u>3 Church St. Cambridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Maryland Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

2067221XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11334**

11352

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wor.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle THOMAS Last WILLIS				4. DATE OF DEATH Month Oct. Day 16 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/17/98	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Robert J. Willis				14. MOTHER'S MAIDEN NAME Katie Quillen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ?			
INFORMANT Eastern Shore State Hospital records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491x IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Feb 9 , 1957, to Oct 16 , 1959, that I last saw the deceased alive on Oct 16 , 1959, and that death occurred at 1007 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S.H., Cambridge, Md. DATE SIGNED OCT 16 '59							
ACTUAL SIGNATURE Thomas J. Dredge				PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-18-59		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) BERLIN Md	
23. FUNERAL DIRECTOR'S SIGNATURE Anne A. Burbage				ADDRESS Berlin Md		24a. REC'D BY REGISTRAR OCT 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

CERTIFICATE OF DEATH

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